Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,137.54 for date of service 03/01/01?
   b. The request was received on 02/22/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/12/02
   b. HCFA(s)
   c. EOB
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/02/02
   b. HCFA(s)
   c. EOB
   d. Reimbursement data
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/23/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 04/24/02. The response from the insurance carrier was received in the Division on 05/02/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   a. "(Carrier) has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges. Also group insurance companies are allowing 100% of our billed charges. Enclosed are examples of bills for the same treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid."

2. Respondent:

   a. "Given these deemed fair and reasonable reimbursements under commission rules, the providers assertion that it is entitled to $5255.54 is not credible. Further the reliance on selected high payment percentage bills is not a reliable or appropriate measure of what is fair and reasonable. This type of evidence was rejected as unreliable in SOAH Docket Number 453-01-1179.M4; 453-01-1263.M4 & 453-01-1263.M4."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/01/01.

2. The provider billed $5,255.54 for the date of service 03/01/01.

3. The carrier reimbursed the provider $1,118.00 for the date of service 03/01/01.

4. The amount in dispute is $4,137.54 for the date of service 03/01/01.

5. The denial on the EOB is "M-"IN TEXAS, OUTPATIENT SERVICES ARE TO PAID AS FAIR AND REASONABLE."

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"
Texas Labor Code Section 413.011 (d) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The provider submitted reimbursement data (EOBs from various carriers) in an attempt to demonstrate payments of fair and reasonable for treatment of an injured individual of an equivalent standard of living in their geographical area. In light of recent SOAH decisions,

showing what other carriers have paid an ASC is not evidence of effective medical cost control and is not evidence of amounts paid on behalf of managed care patients of ASC's or on behalf of other non-workers' compensation patients with an equivalent standard of living. The provider's documentation failed to meet the criteria of 413.011 (d).

Because there is no current fee guideline for ASC(s), the health care provider has the burden to prove that the fees paid by the carrier were not fair and reasonable. The provider submitted EOB(s) from other carriers, but the provider failed to meet the criteria of 413.011 (d). Therefore, no reimbursement is recommended.

The above Findings and Decision are hereby issued this 2nd day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.